PUBLISHED UNDER THE AUSPICES OF THE BRISTOL MEDICO-CHIRURGICAL SOCIETY

# THE BRISTOL MEDICO-CHIRURGICAL JOURNAL

*A Journal of the Medical Sciences for the*

# WEST OF ENGLAND AND SOUTH WALES

UNIVERSITY OF MINNESOTA RECEIVED OCT 13 1949 Oct14'49

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# The Bristol Medico-Chirurgical Journal

*A Journal of the Medical Sciences for the*

## West of England and South Wales

*"Scire est nescire, nisi id me*
*Scire alius sciret."*

JULY, 1949.


# THE PROBLEM OF CUT FLEXOR TENDONS IN FINGERS


BY

A. L. EYRE-BROOK, M.S., F.R.C.S.

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CUT flexor digitorum tendons, when the cut is at the wrist, do exceedingly well if sutured with silk, although the operation is tedious and accurate reconstruction essential. When the cut is in the palm outside the flexor sheath results are fairly good. But surgeons have for long faced a real problem in treatment when the cut is in the fingers: indeed, so great are the difficulties that some surgeons have advocated amputation. It is therefore surprising to find that these cases are still sometimes dealt with by the enthusiastic casualty officer who, during his short stay in this department, rarely grasps the completeness of his failure and who often continues to view the problem as one of cobbling the cut tendons with silk of suitable strength. This practice is not only doomed to failure but usually spoils the field for subsequent surgery.

Let us consider some of the points which complicate the treatment and jeopardize the result in this common injury.

1. A partial success is a failure: because a finger which cannot act with the other fingers either gets in the way, or being held apart

inco-ordinates the action of the hand. A very good result is essential. A cut flexor pollicis longus is a much simpler problem, if only for the reason that the thumb acts on its own and defective flexion is no serious disability.

2. The cut may well be infected.

3. The complicated anatomy of tendon sheaths and retaining slings has to be preserved or reproduced to get good function.

4. Suture material which is strong enough to resist the muscle pull will cause extensive foreign-body reaction and thick fibrous adhesions, unless removed as soon as it can be dispensed with.

5. The skin and subcutaneous scar of the original injury usually overlies the tendon suture and this with the suture material predisposes to a transverse bar of scar tissue. The accidental cut is always *across*, and therefore most liable to tether, the tendon; surgical scars are usually lateral and in the length of the finger.

The surgeon who has done most towards the solution of this problem is Sterling Bunnell of San Francisco. He introduced removable stainless-steel wire sutures, which were strong enough to resist the pull of the muscle and yet caused a minimum of fibrosis during their fourteen days' stay within the tissues. He also made it clear that the best results were obtained when there was no tendon suture within the extent of the flexor tendon sheath in the finger; this frequently makes it necessary to use a tendon graft.

*Immediate suture.* In a small series, the cut flexor profundus tendon was sutured with a stainless-steel removable wire suture and the sublimis tendon excised from the finger and palm; this being done within a few hours of the injury. Results were not very encouraging, largely because the overlying transverse scar of the cut in the skin and subcutaneous tissue adhered to the tendon suture and formed one strong fibrous scar.

*Delayed suture*, allowing the cut to heal and the scar to mobilize before entertaining surgery on the tendon and using correctly planned skin incisions, led to somewhat better results. It has latterly only been used for cuts in the palm and the thumb, which have a much better prognosis than cuts in the finger.

*Delayed tendon grafts.* The common accident, in which the flexor tendons are cut in the finger, has of late been dealt with by delayed tendon graft. The cut is carefully cleaned, damaged skin excised and the fresh edges sutured immediately after the accident. No surgery of the tendon is undertaken until the finger has regained its full passive range of movement and the scar has become soundly healed and shows some mobility over underlying tissues. This interval is usually about six weeks. The muscle of the affected flexor profundus tendon will not atrophy as the tendon does not

retract far. It either becomes attached to the sheath or is held by the lumbricales muscles : it is therefore able to act during use of the hand. A well-planned tendon graft is then carried out under the best conditions for success. The important points in the operation are as follows :

HÆMOSTASIS. Operate under ischæmic conditions provided by a baumanometer cuff after suitable pressure-exsanguination of the hand and forearm. This cuff can be kept on for well over an hour without ill effect, pressure being maintained at 200 mm. of mercury. When the suture of the tendon graft has been completed, some tidying up will be necessary and at this stage it is advisable to deflate the baumanometer cuff. Free capillary and arterial hæmorrhage occurs. The latter should be controlled by an occasional very fine ligature and the former by pressure with a swab soaked in warm saline. Even with these precautions it is still often advisable to drain the incision in the palm as any hæmatoma will ruin the result.

SKIN INCISIONS should be lateral and in the long axis of the finger : and in the creases of the palm. The oblique palm crease is the best, giving quite good longitudinal exposure.

PREPARING THE BED FOR THE TENDON. Both tendons distal to the cut are removed except for the final quarter-inch of the flexor profundus tendon, which is used to receive the distal end of the graft. The lateral finger incision cuts the two retaining pulleys on one side, near their attachment to the phalanges. These pulleys are not resutured. This allows for swelling of the tendon graft without strangulation. Repair of the pulleys will occur naturally so that their essential function is preserved, and the tendon is prevented from acting as a bow string. Any scar tissue at the site of the original cut is, of course, excised *en bloc*.

THE TENDON GRAFT. The flexor profundus tendon proximal to the cut is shortened, if necessary, to bring the suture line just proximal to the distal palm crease. The flexor sublimis tendon proximal to the cut is removed, if necessary up to the muscle belly, to provide the tendon graft of suitable cross-section. The tendon graft can be removed through a fresh incision in the forearm but usually sufficient tendon can be obtained through the palm incision. The graft should be very slightly overlength as some shrinkage does occur. (Figures 1 and 2.) The palmaris longus has been found to be a most unsuitable graft, owing to its small size. The end of the flexor profundus tendon is not " satisfied " by the cross-section offered by the proximal end of a palmaris graft and many " unsatisfied " fibres gain attachment to surrounding tissue, forming a collar of dense adhesions.

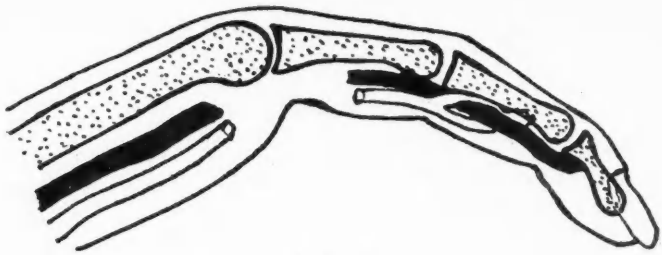

FIG. 1.
Diagrammatic representation of cut flexor tendons in finger.

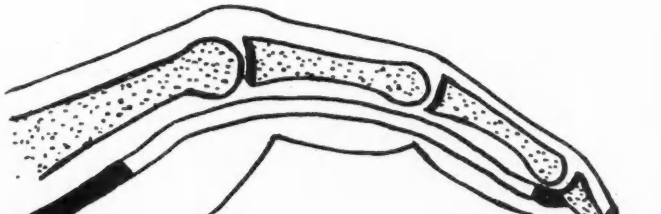

FIG. 2.
Flexor sublimis graft replacing cut flexor profundus tendon; stump of flexor sublimis removed and both ends of the flexor profundus shortened.

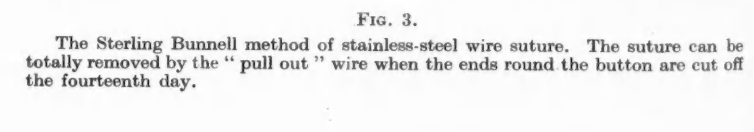

FIG. 3.
The Sterling Bunnell method of stainless-steel wire suture. The suture can be totally removed by the " pull out " wire when the ends round the button are cut off the fourteenth day.

THE SUTURES. Suture is effected at both ends of the graft by removable stainless-steel sutures which are withdrawn on the fourteenth day. The Sterling Bunnell suture is illustrated on facing page. (Figure 3.)

Occasionally the suture line is improved by a very fine suture of 6/0 ophthalmic " mersilk ". As these sutures leave a permanent foreign body, they are avoided whenever possible. If the proximal suture line can be covered with some fatty flap or the base of the lumbricalis muscle, the chances of adhesions are reduced.

CLOSURE. When the surgeon has carefully dealt with bleeding and provided a small drain, the skin is sutured. A firm pressure dressing consisting of a liberal supply of cotton-wool and two crêpe bandages completes the operation.

POST-OPERATIVE TREATMENT. The drain is removed on the second day when the hand is inspected. The wires are withdrawn proximally on the fourteenth day after cutting off the button at the distal end. To avoid any trouble when removing the wires, make a point at the time of the operation of ascertaining that they slip freely backwards and forwards and are not hampered by any kinks. This post-operative routine precludes almost all movement of the tendon during the first two weeks, the suture line being tethered to the skin. Passive movements of the fingers are encouraged once daily and active movements initiated after the removal of the stainless-steel suture. Massage of the scars, when these are thoroughly healed (three to four weeks) is useful and so also is faradic stimulation after six weeks. Occupational therapy helps a great deal in recovering active movements. In a satisfactory case a full range of movement should be obtained in about three months : results can be fairly assessed at this period as little further improvement is to be expected. On the whole it appears that children and young people give the best results.

The suture line has occasionally been exposed at a later operation for adhesions. It has then been found that the best sutures show merely a fusiform enlargement, while in those where the graft is much smaller in cross-section than the flexor profundus tendon there is a collar of thick adhesions from what may be termed " unsatisfied " fibres of this tendon. The graft always appeared white and glistening and showed no yellow degenerative changes.

It will be noted that only the flexor profundus tendon has been reconstructed by suture or grafting and that the flexor sublimis tendon has been removed *in toto*. This practice is now invariable as one finds good results sufficiently difficult to obtain when concentrating on one tendon without adding the complicating factor of having two tendon sutures both requiring the opportunity to swell and to form fusiform unions, usually at approximately the same level. Adhesions are consequently much greater where both tendons are preserved,

and the results are inferior. It is quite surprising how excellent the function can be in a finger which has lost the action of the flexor sublimis. The illustrations demonstrate that the flexion is almost complete in both joints. (Plate VIII.) The patient was shown at the clinical meeting in December. This boy can demonstrate perfect function by allowing his middle finger to assist in flexing the index finger, the former lying slightly posterior to the latter. In the photograph no such trick is being used.

A not uncommon lesion is division of the flexor profundus tendon distal to the insertion of the flexor sublimis. Here the disability is very much less than when both tendons are severed. The middle joint of the finger, designed to bend well beyond the right angle, continues to function normally : while the distal joint, which only bends to considerably less than a right angle, ceases to function. Some surgeons do repair the flexor profundus tendon in such cases but there is a definite risk of impairing the perfect flexor sublimis function. There is a great deal to be said for leaving such cases entirely alone. Fixation of the distal joint at 135 deg. is a safe procedure if it is felt that surgery is called for to improve function.

The surgery for cut flexor tendons in the fingers provides a very exacting and interesting study. It certainly warrants the skill of a fully trained surgeon and excellent results can be obtained. The pessimistic conclusion that amputation of the finger is called for is quite unwarranted, as also is the optimistic conception that the treatment lies within the province of the surgery undertaken in the casualty department. The finger is one of the smallest members but the whole arm exists solely to serve the thumb and four fingers. How much of our time and effort is directed towards getting these prehensile members into action !

## PLATE VIII

Flexor tendon graft, index finger. Sublimis graft, profundus motor.

FIGURE 4.
Straight fingers.

FIGURE 5.
Fingers clenched; middle finger definitely *not* helping index.

## PLATE IX

FIG. 1.
Osteomalacic deformity.

FIG. 2.
Osteomalacic deformity. Arm, leg and pelvis after Caesarean.

FIG. 3.
Osteomalacia, showing triradiate deformity of brim, contracted outlet and osteoporosis.

# THE DRAMATIC IN GYNÆCOLOGY AND OBSTETRICS*

BY

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THE *Oxford Dictionary* defines drama as "a set of events having the unity and progress of a play, leading to catastrophe or consummation". That being so, I am very conscious of the fact that in my career the dramatic faced me early. It was in 1904 when I was on the district all by myself in that unsavoury part of Bristol which used to exist to the right and left of those interminable steps which lead directly north opposite the Royal Infirmary. In those days there was no antenatal care and the "doctor" was only called when labour had begun. I remember I had been up all night waiting plaintively for the high bulging membranes to rupture. At last as dawn was breaking I plucked up courage and despatched a greasy note by the poor husband to Dr. Stack the R.O.O. He wrote back on the note "rupture them yer fool!" As my fingers slipped and slithered, being unable to scratch their way through the membrane, I used a pair of scissors. Out gushed brain and liquor cerebri in vast quantities. It was a case of hydrocephalus!

Since then I have worked and wandered in many lands. Working in this country one tends to forget the frightful deformities of osteomalacia and the skill necessary to deliver such patients. Indeed, I think that few of us realize the grand work that is done by missionary doctors and civil surgeons in many parts of the Empire. I do not speak only of a nightmare craniotomy through an outlet of perhaps only two inches, but rather of the Caesarean where owing to fixity and flexion of the thighs, the lower segment cannot be reached and the only portion available, or for that matter, visible, is the fundus. You may well imagine what tragedies and injuries occur and what the drama of a live childbirth is to all concerned. (Figures 1, 2, 3.)

Another urgent problem of the East is the flabby abdominal wall with a flabby uterine wall and a flabby cardiac wall, which so

* An address delivered to the Bristol Medico-Chirurgical Society on Wednesday, 9th February, 1949.

often complicate labour and terminate in tragedy. I recall one such patient, an Englishwoman, who had not only the typical pendulous belly of the Orient, but also an umbilical hernia. (Figure 4.) Despite all care to prevent disaster, this patient died of shock immediately following acute inversion, although the attendant knew full well what might occur and did his utmost to avert catastrophe.

I shall show you slides of Elephantiasis vulvae, a condition also quite commonly seen to-day in the West Indies, and a radiograph of the foetus *in utero*, demonstrates the high degree of moulding which had occurred after death of the foetus.

There have been times when literally even my scanty hair has almost stood on end. For instance, I recall an incident when I was applying forceps and not difficult ones at that, when suddenly I heard a sound like the crack of a pistol; the symphysis had ruptured and one could put two fingers between the pubic bones. Mother and child did well, however.

I remember another occasion when I was called by a doctor at dead of night to a patient's house to apply forceps. The lady had been in labour a long time and was lying on one of those huge, soft, sagging double beds. I placed her buttocks over the hard edge of the bed, not at the time realizing that the rest of her body was almost in the Trendelenberg position. As I adjusted the forceps, the foetus uttered a prolonged wail, identical in every way to that of a new-born babe—a wail that was plainly heard by everybody in the room, and before I could deliver that child, this awe-inspiring, hair-raising, vagitus uterinus was repeated four times. The infant was born alive and did well.

Another horribly dramatic experience, one that must have occurred to some here, was when I heard the humerus crack while my resident lady doctor was bringing down an extended arm in a difficult breech presentation.

*Opéra bouffe* has occasionally come my way. For instance a few years ago I was asked to see a case of supposed hydatidiform mole. The uterus was considerably larger than it should have been for its dates and there was a slight sanious discharge. As the uterus was up to the umbilicus and no foetal heart sounds could be heard, I suggested that an X-ray might help. No foetus was visible, but as you will see, a Graffenberg ring was jauntily embedded in the placenta. (Figure 5.) The patient went to term with twins: and when the silver ring was dug out afterwards from the placenta, she wore it as a brooch for many years!

I remember being called to a nursing home in Chingford in Essex one cold, foggy night. The Irish doctor on the 'phone said it was a case of acute hydraminos and that the patient was very ill. When seen she presented a tense, shiny, distended abdomen; the tumour was obviously fluid. On passing a catheter I let out fourteen pints

# PLATE X

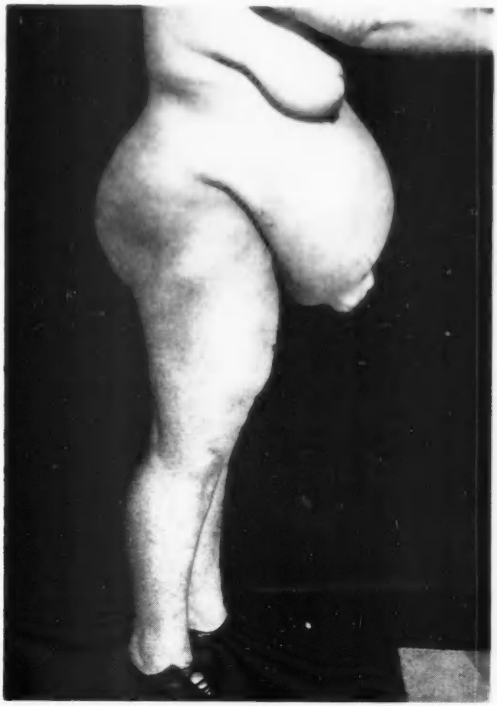

FIG. 4.
Pendulous belly with umbilical hernia in primipara—subsequent inversion and death.

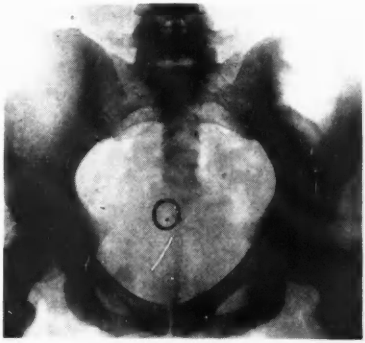

FIG. 5.
Graffenberg ring in situ in case of twins at fifth month.

## PLATE XI

FIG. 6.
Large ovarian cyst.

FIG. 7.
Obstruction by round worm infestation simulating ovarian cyst.

of urine in the course of three hours. She went to term after replacement of the uterus and the wearing of a catheter for a week. Slow decompression is not necessary in such cases.

Coming to gynaecology, Figure 6 shows one of two cases that I saw during the bombing of London in 1941. Both were Christian Scientists and both were patients whose relatives had refused to stay with them in much "blitzed" Fulham. The removal of such colossal tumours is of course dramatic: but provided one can prevent shock, anyone who has been trained in the Tropics need have no fear, for such tumours even to-day are to be seen there every week.

Figure 7 is in a sense even more remarkable; for here the abdominal swelling is not due to tumour, pregnancy or ascites, but to chronic intestinal obstruction caused by the accumulation of roundworms by the ten thousand, a condition only to be seen in the Tropics. The effect of the treatment was indeed dramatic.

The problem of fistulae and particularly the persistent vesico-vaginal fistula, whether seen here or abroad, is a dramatic one. Who has not heard such a patient say "let me be dry or die"? Compare the breath-taking beauty of young West African pagans before marriage, and the appearance a few years later of two of these girls after a complicated labour resulting in large vesico-vaginal fistulae necessitating sigmoidal implantation of the ureters.

There is an idea prevalent here, fostered by Oxford, that all such fistulae can be cured vaginally by silver wire. Believe me, that is nonsense: for the size and edges of these holes have to be seen and felt to be believed. Consequently it is imperative that every missionary doctor or otherwise proceeding to the Tropics should be absolutely conversant with the technique of implantation of the ureters into the bowel. This operation indeed combines drama with thanksgiving.

Which of you has not seen the high recto-vaginal fistula that has defied two, three or even more attempts at closure? Only recently I had such a case sent to me. Yet if the technique be changed, what melodramatic rejoicing follows success.

In 1937, I visited Alexandrov's clinic in Moscow. His operating theatre had two tables in it—the first was occupied by a patient having a myomectomy and simultaneously a cadaver blood transfusion; whilst on the other sat a tough-looking girl avidly watching the proceedings whilst awaiting her own spinal anaesthetic.

One of my most dramatic memories concerns being directed by the Foreign Office to proceed to Nepal and do a hysterectomy on a V.I.P. The journey took five days by train, elephant, foot and dandy, that is, carrying-chair, up and down the mountains. On arrival my horoscope was first carefully read and when declared lucky (for my birthday is on August 14th which means the happy conjunction of some particular stellar units) I was asked the following

day to operate in the excellent public hospital of Khatmandu on two Nepalese women who presumably had the same fibromatous condition as Her Excellency. These surgical results being satisfactory, a bedroom with marble walls and floor was selected in a wing of the palace as the theatre.

The day, the hour, the minute for the laparatomy was next fixed by the soothsayer. That morning began a play reminiscent of ancient Rome. The very charming lady dressed in a new white silken sari with her hair decked with sprigs of fresh corn and rice, and most conspicuous of all, a banana, supported by two female attendants, walked slowly down a long white marble corridor lined by a host of her retainers to whom she threw as largesse, gold, silver and copper coins. Her husband and I with my theatre staff very humbly followed behind. She showed no signs of fear. Throughout the operation, which was watched by a hundred pair of eyes glued to the jhilmills and arabesque slots in the walls, one heard guttural wah! wahs! It was an endometrioma. I was paid in a leather sackful of silver rupees which even the elephant eyed askance when put upon its back!

Even to-day tragi-comic incidents occur. For instance, not so very long ago I saw a well-known actress in consultation who had had an emergency laparotomy on the diagnosis of a twisted ovarian cyst. Nothing, however, was found. A few weeks later after she had gone back to the stage, it was realized from her gums that her recurrent acute abdominal colic was due to lead which was being absorbed from her 'make-up'.

Quite recently another comedy came my way. An ex-proconsul from India had married a very charming girl who, because she was a bad diabetic and insulin resistant, had been told by expert physicians never to risk pregnancy. She was therefore sent to the Highest Priestess of Lady Doctor Cap Fitters. Six months later I was asked to see her. She was four months pregnant and on examination I found she had two perfect vaginae and two perfect uteri. Over the cervix of one was a metal cap! The husband had gone the other way. The High Priestess had missed the double doors. She was not amused when a lawsuit for damages was on the tapis. I did a Caesarean at full term and got a live baby. A few months later I persuaded the lady to have the hysterogram done which I show you (Figure 8).

As you know, prolapse is the bane of every Outpatient Department, but I doubt if we here outdo the East in this respect, for there it is often complicated by prolapse of the anus. It is not my intention to pause over the surgical side of such a problem, but I want to remind you that the ancient Egyptians knew all about prolapse. When the perineum was moderately intact, they employed hollow ball-like pessaries made of clay from the delta of the Nile

# PLATE XII

Fig. 8.
Double uterus. Double vagina.

# PLATE XIII

FIG. 9.
Elephantiasis nostra of vulva.

I thought you might like to see the types of pessary used by these small women which were actually removed from the bodies of mummies. To me this is peculiarly interesting, for I have seen such supports *in situ*, worn by women living in Baghdad and in the valley of the Ganges. To-day if the perineum is good and a cystocele is the main discomfort, a ping-pong or rubber ball are excellent palliatives.

Even in the use of lipiodol, dramatic moments occur. I shall not lightly forget the appearance of the first salpingogram that I ever did in 1925, when by mistake I removed the nozzle of the syringe before the picture was taken; nor need I remind you of the dramatic importance of this method of investigation when there is a history of miscarriages. I show you the double uterus of a distinguished doctor's wife who had had four miscarriages for which no cause whatever could be found until the radiograph showed it. Occasionally of course one has the alarms and excursions of oil embolism and perforation, but they are very rare and *not* dangerous like air embolism with its tragic deaths on the table, that is if you should still use air rather than carbon dioxide. I have had just such a death and can never forget it, and recently there was another in London.

Some may think that nowadays we are so advanced that the old-fashioned disasters no longer occur. Let me tell you of a case that arrived by air quite recently from Singapore. The lady had had a live baby with some forceps difficulty. Three days later she developed general peritonitis for which the abdomen was twice opened and drained. She recovered: but pus continued to pour from the wound for eight months. Suddenly one day hairs were seen in the pus—it was at once realized that the foetal head had compressed and burst a dermoid cyst of the ovary. She was then sent home by air. That cyst was the size of a tennis ball, deep down in the pelvis and surrounded by matted coils of bowel. I found the removal a nightmare! You can see the teeth outlined in the lipiodologram.

Figure 9 shows a case of elephantiasis nostra which occurred in the wife of a Wessex dentist. She was twenty-six and had never been out of this country. Vulvectomy was performed necessitating Caesarean section the following year—a set of events, as the definition goes, having the unity of a play leading to consummation.

# CHOLECYSTITIS DUE TO LIVER FLUKE*

BY

G. P. O'DONNELL.

*Surgeon, Redruth Hospital*

MRS. C. aged fifty, of Cornish origin, who had never lived outside England, was admitted to the Redruth-Camborne hospital suffering from severe recurring upper abdominal pain. For two years previously she had complained of vague epigastric discomfort and flatulence. For the past six months the pain had become colicky in character, increasing in severity and frequency and localized in the right hypochondrium.

On examination, there was well-defined tenderness with muscular guarding over the right upper rectus. X-ray showed a poorly functioning gall-bladder: no calculi were seen. Blood findings were leucocytes 16,000, otherwise normal (eosinophils 2 per cent). Diagnosis—Cholecystitis.

*Operation.* There were dense adhesions between the gall-bladder and the adjacent viscera. The gall bladder was normal in size, white and opaque. The walls were thickened by fibrous tissue and deposits of fat. There were two equally developed cystic ducts, one being continuous with the neck, the other arising a short distance above it. Each opened separately into the common duct. The gall bladder was removed. The common duct was dilated. No obstruction was found either from stone or stricture, nor was there any hardness or enlargement of the head of the pancreas. On exploration two living, fully developed liver flukes were removed from the upper end of the duct. Nothing abnormal was found in the distal end and the sound passed freely into the duodenum. The common duct was drained. She ran a normal course, and was discharged healed within three weeks. The bile and faeces were examined on several occasions whilst she was in hospital and again six weeks after discharge. No ova were ever found.

Before leaving hospital she was put on a course of emetine, one gram being given daily hypodermically for fourteen days. Since the operation she has not complained and at present seems quite well.

Cases of diagnosed parasitic infection due to liver fluke (Fasciola Hepatica) are rare. Up to 1945 Manson-Bahr recorded 150, mainly from Cuba. The other reported cases were from Argentine, Hungary, Germany, Switzerland, Greece, China and England.

* Report presented to Truro Medical Society on 1st February, 1949.

In England the fluke occurs most frequently in sheep, where it produces the disease known as "Liver Rot". It is also prevalent in cattle to a larger extent than was suspected. The average incidence in apparently healthy cattle, based on the examination of 73,000 slaughtered in June, 1942, was 17.3 per cent. The percentage was higher in the North than in Southern England.

The life cycle of the liver fluke is complicated. It lives in the bile ducts of the primary host, i.e. sheep, cattle and man; duration of life is stated to be probably about eighteen months. Each fluke can produce up to 50,000 eggs at once. These are excreted in the faeces and can live in water or damp grass for upwards of five months, before hatching with the consequent liberation of the miricidum—the first larval stage. The miricidum quickly perishes unless it finds the intermediate host, the water snail. In the snail it undergoes three further stages of development in six to seven weeks. On leaving the snail there is a final stage of development into the metacercaria. In this stage the larvae are very resistant. They can live in water for fourteen days; up to forty-eight days when completely dry; and in a refrigerator in a moist medium for eleven months.

The metacercaria is the infective stage for the primary host, being ingested in water or uncooked vegetables, e.g. water-cress. The larvae pass through the stomach unaltered. On reaching the small intestine the cyst corm is dissolved, freeing a young fluke. The young fluke bores through the intestinal walls into the abdominal cavity. It reaches the surface of the liver through the peritoneum, burrows through the fibrous capsule and the liver substance producing necrosis and finally comes to rest in the bile ducts. It has been suggested that at times it passes directly to the liver through the common duct.

On occasions it enters the blood-stream and comes to rest in different parts of the body, such as the brain or under the skin. If it lodges in any region except the liver the young fluke dies and undergoes calcification or forms a sterile abscess. In the bile ducts it becomes a mature hermaphroditic parasite in about three months and lays eggs, thus starting a new cycle.

*Symptoms.* In mild cases of infection there is slight gastro-intestinal disturbance, such as dyspepsia, alternating diarrhoea and constipation. In the more severe cases there is hepatic colic, due to mechanical irritation, acute cholecystitis or jaundice if the bile ducts become blocked. There are rigidity and tenderness of the abdominal walls during migration of the parasites. Frequently there is urticaria, as with other parasitic infections, due to sensitation to foreign proteins. There is persistent diarrhoea. The severe cases are accompanied by a leucocytosis up to 50,000, but usually

in the region of 20,000. In the acute early cases this is due largely to an absolute increase in the eosinophils, which may be up to 60 per cent. and in part to liver damage and incidental infection.

Chronic cases develop anaemia which is due to two causes: primary toxaemia producing a secondary anaemia in the early stages, followed by macrocytic anaemia of cirrhosis in later stages. As the anaemia progresses, leucocytosis diminishes and there may be finally a leucopoenia. Boycott says the anaemia is due to toxic action causing aplasia of bone marrow. Wintrole ascribes it to hepatic insufficiency leading to lack of the "Anti-pernicious principle". Anaemia in fluke infection is differentiated from pernicious anaemia by uniformity of macrocytes; anisocytosis is not present, but there may be some poililocytosis. Achlorhydia is unusual.

Changes in the liver of infested animals are due to mechanical irritation and toxic action of the parasites. The superficial ducts are hypertrophied and sclerotic and the lumina are constricted, containing a dark substance consisting of muco-pus, ova, parasites and their faeces. In later chronic stages large convoluted cavities are present. These are formed by intercommunication of large bile ducts which become dilated owing to peripheral blockage. There is excess of fluid in the abdomen. The liver is small and sclerotic. If the animal dies in the acute stage, the liver is enlarged, haemorrhagic and friable. Usually blood-stained fluid is found in the abdomen. Large numbers of immature flukes can be expressed from the cut liver surface.

*Treatment.* Treatment should start on the farm, by clearing stagnant ditches, removing and burning the contaminated weeds and grass; and treating the land with copper sulphate. If the sheep are infected they are treated with carbon tetrachloride (1 mil. in capsules, monthly from October to April): in man give emetine injections, 0.5 cg. per kilo of body weight.

Anti-bodies are produced in the blood as with hydatid infection and can be detected with a skin test, using dried extract of the parasite. Some immunity has been conferred on rabbits by injecting increasing doses of dried parasites. This is still in the experimental stage, but may be of importance in prevention of infection in sheep.

# SOME DISEASES OF THE NEWBORN BABY.*

BY

A. A. MONCRIEFF, M.D., F.R.C.P.

*Nuffield Professor of Child Health, University of London.*

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OF 800,000 babies born each year about 17,000 die during the first four weeks of life, and of these deaths roughly half are said to be due to prematurity. Let us assume that few babies actually die from immaturity alone, and ignore this aspect of the subject and concentrate on the other main causes of death as classified by the Registrar-General.

*Congenital Malformations.* At one time it was believed that these were largely due to gene mutation, but it is now appreciated that there are equally important causes amongst the commoner of which are the position of a foetus *in utero*, maternal infection (virus diseases of the pregnant mother), specific dietetic deficiencies in the mother and also the possibility of damage by X-radiation to the ovarian follicles.

*Asphyxia.* The number of newborn children dying from asphyxia is higher than the number of children under fifteen who are killed on the roads. Asphyxia may be due to respiratory failure or actual suffocation. Adrian in his work on action currents has shown that preparation for respiration takes place before birth. Barcroft has shown that the necessary stimulus to commence respiration after birth is small. There are two centres concerned ; the gasping centre and the " $CO_2$ controlled " centre. The first gasp is initiated by the gasping centre and is induced by diminution in the oxygen supply when the cord is cut or the placenta separated. Once the first gasp is taken the " $CO_2$ controlled " centre carries on. The effect of sedative drugs on the respiratory centre must, therefore, be borne in mind. Many babies that die of asphyxia have, in fact, been drowned by premature inhalation of amniotic fluid or mucus and this should always be borne in mind when prescribing drugs for the mother.

*Treatment.* These cases can be largely overcome by having a proper plan for dealing with the baby soon after birth.

As soon as the baby is born, care should be taken that the upper respiratory passages, including the naso-pharynx, are absolutely clear ; this may be accomplished both by swabbing and suction.

* An address to Torquay and District Medical Society on 10th February, 1949.

The baby's laryngeal fissure is so tiny that the space between the cords may be occluded by even a very minute piece of mucus.

Clamp the cord at once to produce physiological stimulus for the gasp centre. It is probable that the last few drops of blood in the cord are of no particular value to the child anyway.

Keep the baby's head low for the first few hours after delivery to prevent aspiration of mucus.

Artificial respiration does no good unless, possibly, given by a rocking machine. The ordinary methods produce trauma only.

*Birth Trauma.* Injuries to the long bones, though regrettable, do not result in death, which is generally produced by cerebral injuries—often following instrumentation. Intracranial hæmorrhage is almost invariably fatal except in a few cases where it is sub-dural. However, after instrumentation there is occasionally œdema and congestion. In such cases the baby is concussed and the symptoms take two to three days to develop, whereas in cerebral injury the symptoms develop at once. Common symptoms are that the child becomes comatose or may show irritability. The fontanelle becomes tense and there may be neck or leg stiffness accompanied by vomiting, respiratory difficulties and reluctance to feed. The treatment for these cases is to keep the child in a dark room and flat. Oxygen should be given, as the danger to the baby is anoxæmia. Good nursing is most essential and the normal feeding should be kept going. Sedatives should be given—chloral is the best. To reduce intracranial pressure, hypertonic saline (2 oz. of 10 per cent. solution) should be run into the rectum two or three times and allowed to stay there until rejected. This line of treatment will prevent death in most borderline cases ; the ultimate effect, however, cannot be foreseen and though many of the cases may become quite normal, some later develop spasticity.

*Infection.* The number of babies dying from infection is probably underestimated ; the picture of infection in infancy is not typical. Two points in particular are not appreciated ; the first is that the very mildest sign of sepsis in the infant indicates danger ; and second, the normal temperature in infants is probably between 96 deg. and 97 deg. and not 98 deg. as in the adult, so that a child showing an apparently normal temperature may have a hyperthermia of 1.5 deg. to 2 deg.

The question now arises of transferred immunity from mother to child. It is possible that placental transference may give some passive immunity to the child against diseases to which the mother is immune, but it is probable that this immunity rapidly passes off. It is uncertain whether any antibodies are transferred via the colostrum. It is certain that many infections to which the mother is not immune may affect the child from birth and this applies in particular

to the common cold and pyogenic infections. The common cold virus is probably a common infection in the newborn child but its symptoms are not easily perceived : any baby with diarrhœa and vomiting, tendency to blueness and reluctance to feed is probably infected. If those who are in attendance on the child are examined it is almost certain to be found that one of them has a cold. In such cases if the infant dies it is usually from nasal obstruction, because it is not the habit of babies to breathe through the mouth. Such cases should not arise and it is advisable that all in attendance on the child should wear masks.

So far as the pyogenic infections are concerned, the primary infection may be negligible and may present the minor degree of paronychia, ophthalmia, nasal catarrh or infection of the cord stump. Following such minor degrees there is the general picture of sepsis neonatorum. The baby stops feeding, vomits, ceases to gain weight (all alimentary symptoms). It becomes anæmic and grey ; or there may also be jaundice and œdema of the legs. A short and usually fatal stage is that of pyæmia with pemphigus, boils and bronchopneumonia. Take primary infections seriously and treat at once with penicillin by the mouth. When the stage of sepsis neonatorum develops, penicillin is not only given by the mouth but 4,000 units per pound of body weight per day should be given intramuscularly and in addition sulpha-methazine for five days. It is important to keep the infant on the same foods as it has been having hitherto. The symptoms are those of gastro-intestinal disturbance, so the feeding comes under suspicion and is changed : it is better to avoid this, as the child has enough to cope with as it is, without the added upset of dealing with an unaccustomed diet. Strict watch should be kept on the blood-count and transfusion undertaken if necessary.

# Reviews of Books

**Elementary Atlas of Cardiography.** By H. WALLACE-JONES, M.D., M.Sc., F.R.C.P., E. NOBLE CHAMBERLAIN, M.D., M.Sc., F.R.C.P. and E. L. RUBIN, M.D., F.F.R., D.M.R.E. Third Edition. Pp. 108. Illustrated. Bristol: John Wright & Sons Ltd. 1948. Price 12s. 6d.—This little book of just over a hundred pages gives the student a sound elementary introduction to the difficult subject of electrocardiography and cardiac radiology. The illustrations throughout are good. The book fulfils its function admirably and can be thoroughly recommended.

**Physical Signs in Clinical Surgery, Pts. I–IV** (complete). By HAMILTON BAILEY, F.R.C.S., F.A.C.S., F.I.C.S., F.R.S.E. Eleventh Edition. Pp. xiii, 426. Illustrated. Bristol: John Wright & Sons Ltd. 1948-49. Price 8s. 6d. per part.—Shortages of bookbinders and of colour-block makers caused the author to lose patience and to decide to issue this edition in paper covers, and in four parts. As in former editions, the illustrations, 657 in number and mostly coloured, constitute by themselves a liberal education in surgery for student, practitioner and surgeon alike. The text also is very good and thoroughly up to date. Some of the information would be hard to come by elsewhere, and gives evidence of wide reading.

**Cardiovascular Disease.** By TERENCE EAST, D.M., F.R.C.P. Third Edition. Pp. 218. Illustrated. London: H. K. Lewis & Co. Ltd. 1949. Price 15s.—The fact that a third edition of this valuable little book has been needed in little more than three years is ample proof of its well-deserved popularity. It provides in simple and clear style a very comprehensive review of cardiovascular disease for the general practitioner. It is surprising how much information it has been possible to convey in a comparatively small book by eliminating all but essentials. Throughout, the physiological approach to the problem is maintained and the reader is shown how to approach cardiovascular problems from first principles. In this new edition some additions have been made and the whole has been brought up to date. This is a book which can be thoroughly recommended as a sound guide to cardiovascular diseases, both for the practitioner and student.

**Medical Annual, 1948.** Edited by SIR HENRY TIDY, K.B.E., D.M., F.R.C.P. and A. RENDLE SHORT, M.D., B.S., B.Sc., F.R.C.S. Pp. 414. Illustrated. Bristol: John Wright & Sons Ltd. 1948. Price 25s.—The sixty-sixth volume of the *Medical Annual* maintains the standard for which it has always been noted. It is unquestionably the best annual of recent advances in medicine and surgery that is published

anywhere in the world. Everything concerned with recent progress from abdominal surgery to vitamins and nutrition is discussed in an interesting manner by recognized masters in the profession. It should be found in the library of every up-to-date medical practitioner.

**Clinical Endocrinology.** By A. P. CAWADIAS, O.B.E., M.D., F.R.C.P., Pp. iv., 362. Illustrated. London: Frederick Muller Ltd. 1947. Price 42s.—Instead of the usual approach from the point of view of physiology and pathology, Dr. Cawadias, as stated in his preface, here discusses endocrinology from the clinical point of view and he sets out for the practitioner an interesting and up-to-date exposition of diseases of the ductless glands. As would be expected, the work is accurate and shows evidence of wide and mature knowledge, and perhaps the only criticism would be that occasionally rather cumbersome phrases are interjected. Both for the student and the practitioner this book will prove a very helpful companion in his studies.

**The Clinical Apprentice.** By John M. NAISH, M.D., M.R.C.P., and JOHN APLEY, M.D., M.R.C.P. Pp. xi, 200. Illustrated. Bristol: John Wright & Sons Ltd. 1948. Price 15s.—The writers state that "this book has been written expressly for students receiving their clinical training in medicine". After a general survey, the various systems of the body are then considered from the point of view of the clinical approach and a helpful concluding section considers the problem of the acute case. Coma, meningism, hyperpyrexia, dyspnœa and fits are briefly but helpfully discussed and in the next edition it would be helpful to say more about cyanosis. Generally speaking, the information is accurate and precise and only a few errors incidental to a first edition are found here and there. While admitting the importance of feeling the pulse, it is not correct to delude the student into thinking that he can estimate blood-pressure in that way to such an extent that he may gain for himself the reputation of being "a human sphygmomanometer". Sterterous breathing is by no means a necessary feature of deep coma. Such errors, however, detract but little from a book which can be said to be a helpful introduction for the student who is commencing his clinical career.

# Obituary

## WILLIAM ROBERT ACKLAND, M.D.S. (BRISTOL), M.R.C.S.

WILLIAM ROBERT ACKLAND died on July 26th at the age of eighty-five. He was educated at Torquay, at Charing Cross Hospital and at the Royal Dental Hospital, where he won the Saunders Scholarship and many prizes. He took the L.D.S. in 1884 and the M.R.C.S. in 1886, and was soon after appointed Assistant Dental Surgeon to Charing Cross Hospital. In 1888 he was elected the first Honorary Dental Surgeon to

the Bristol Royal Infirmary, settled in Bristol and joined the Bristol Medico-Chirurgical Society. He was a member also of the Odontological Society, later the Odontological Section of the Royal Society of Medicine (President, 1922) and the British Medical Association (President of the Bath and Bristol Branch, 1914 and again 1933). He made many contributions to discussions and to professional journals, especially on the relationship between dental and general disease: and devised a set of instruments for the drainage of the maxillary antrum through a tooth-socket. During the 1914 war he was appointed Major, R.A.M.C., on the staff of the Second Southern General Hospital. He was a member of the Dental Board and also of the General Medical Council, a very active member of the teaching staff of Bristol University and promoter of the University Dental Hospital. In 1913 he was awarded the degree of M.D.S., Bristol: and in 1924 was appointed to the Consulting Staff of the Bristol Royal Infirmary.

Ackland added to a wide knowledge of his speciality an unusual charm of manner. In his younger days he was a keen fox-hunter: and always a lover of pictures and a generous patron of artists, as the walls of his house bore witness. Another feature of his home was a ball-room in which he gave memorable children's parties. He married in 1917 but his wife predeceased him.

# Meetings of Societies

DISAPPOINTMENT has been expressed that the meetings of this or that Society are not reported. The Editor would remind secretaries and local correspondents that he is dependent on them for all such reports—and cannot publish what he does not receive. Papers already published elsewhere and lists of cases shown at clinical meetings are usually of little general interest.

## BRISTOL MEDICO-CHIRURGICAL SOCIETY

THE fifth meeting of the session was held in the University on Wednesday, 9th February, the President, Professor Drew-Smythe, in the Chair. Mr. V. B. Green-Armytage described his experiences in a paper entitled **"The Dramatic in Obstetrics and Gynæcology"** (p. 69), with lantern slide illustrations.

The sixth meeting was held on 9th March. Mr. J. A. Boycott gave an address on **"The Prophylactic Uses of Chemotherapy"** which we hope to publish in our next issue.

The seventh meeting on 13th April was attended by a number of local correspondents to the *Journal*. Mr. Geoffrey Keynes showed an excellent film of the operation of **"Thymectomy for Myasthenia Gravis"** and described the indications for and the results of the operation.

The eighth meeting of the session was held on 11th May. Dr. G. E. F. Sutton read a paper on **"Coronary Thrombosis,"** with special reference to the use of the electrocardiograph in diagnosis and prognosis.

### DEVON AND EXETER MEDICO-CHIRURGICAL SOCIETY

A CLINICAL meeting was held on Thursday, 21st April, 1949. Cases, specimens and X-rays were shown.

Cases and notes on cases were given by the following: (1) Mr. Darke and Mr. Lock, "**Spindle-celled Sarcoma of Groin**"; (2) Mr. Greenberg and Dr. Fuller, "**Subacute Bacterial Endocarditis**"; (3) Mr. Gairdiner, "**Multiple Gastric Ulcers**"; (4) Mr. Daly, "**Five Cases of Meningitis**"; (5) Mr. Greenberg and Dr. Seward, "**Anaemia due to Sepsis and ? Amyloid Disease**"; (6) Mr. Scott, "**Four Cases of Mastoiditis**".

### TORQUAY AND DISTRICT MEDICAL SOCIETY

THE Society's activities have been well maintained during the 1948-49 session. During the past year, six new members were elected, while six resigned. The membership at present stands at 124.

Speakers during the past year were: Dr. Charles Hill, Professor Chassar Moir, Dr. G. D. Kersley, Mr. M. F. Nicholls, F.R.C.S., Professor Alan Moncrieff, Mr. R. Belsey, F.R.C.S., Dr. D. W. D. Brooks.

The session commenced with a dinner and dance at the Grand Hotel, Torquay. Three interesting clinical discussions were held.

### PLYMOUTH MEDICAL SOCIETY

#### PROGRAMME 1949–50

Oct. 5th (Greenbank, 8.30 p.m.). Annual General Meeting.

Oct. 26th, Dinner and Dance.

Nov. 11th and Dec. 16th (Greenbank, 8.30 p.m.). Clinical Meetings.

Nov. 25th, Mr. V. E. NEGUS: "**The Protection of the Air Passages**" with film.

### THE WEST COUNTRY PHYSICIANS' CLUB

THIS club met in October, 1948, at Cheltenham. Dr. C. Seward, "**The Clinical Approach to Anaemia**"; Dr. W. A. Lister, "**Thrills and Swoons**"; Professor A. V. Neale, "**Problems of Diabetes Mellitus in Childhood**"; Dr. P. C. Gibson, "**Salicylic Acid in the treatment of Coronary Thrombosis**"; Dr. R. F. Jarrett, "**Noma and Cancrum oris. Experience of 200 cases**".

At Truro in May, 1949. Dr. C. J. Fuller, "**Symptomatology of Carcinoma of the Bronchus**"; Dr. A. M. G. Campbell, "**Neurological Complications of Mumps**"; Dr. R. G. M. Longridge, "**Intra-arterial injection of Histamine for Peripheral Vascular Disease**"; Dr. C. R. Croft, "**Polycythaemia Vera**"; Professor C. B. Perry, "**Acute Rheumatism as a Notifiable Disease**".

The next meeting will be at Bath in October, 1949.

### THE SOCIETY OF ANAESTHETISTS

THE Society of Anaesthetists of the South-Western Region have held meetings at Taunton in April and in July at Plymouth. The third Annual General Meeting will be held in Bristol on 25th and 26th November when Dr. Beddard of Bath and Frome will be inaugurated as President. Details of the Bristol meeting can be obtained from the Hon. Secretary, Dr. G. L. Feneley, Avon Lodge, 8 Parry's Lane, Bristol 9.

### ASSOCIATION OF CLINICAL PATHOLOGISTS

WESSEX BRANCH—*Secretary :* Dr. D. Woodman

MEETINGS have been held as under : November, 1948 : Canynge Hall, Bristol. 18th May, 1949 : Salisbury.

Programmes for next session : 26th November, 1949 : Dorchester. May, 1950 : Truro.

### BRITISH MEDICAL ASSOCIATION

BATH, BRISTOL AND SOMERSET BRANCH

A MEETING of the above Branch was held on 16th February at the United Hospital, Bath. Professor Alexander Haddon gave an address on **" Recent Advances in our Knowledge of Neoplastic Growth ".**

A clinical meeting was held at the Bristol General Hospital on 23rd March.

WILTSHIRE BRANCH

THE annual meeting was held at the County Mental Hospital, Devizes, on Sunday, 19th June. Mr. A. Duff was elected Chairman for 1949-50.

BRISTOL DIVISION

ON 27th April, at the University, Sir Henry Cohen delivered a lecture on **" Recent Advances in Therapy ".**

The Annual General Meeting was held on Tuesday, 17th May.

*Executive Committee*, 1949–50

*Chairman :* Dr. W. Woolley. *Chairman Elect :* Dr. G. E. F. Sutton. *Hon. Secretaries :* Dr. H. M. Golding and Dr. W. H. Hayes. *Hon. Treasurer :* Dr. C. Dix.

*Representatives on Representative Body :* Dr. A. G. Heron, Dr. T. Milling, Dr. Winifred G. Nott, Dr. P. Phillips, Dr. W. Woolley. *Deputy Representatives :* Dr. W. H. Hayes, Dr. R. MacLean Courtney, Mr. F. J. Hector.

*Representatives of Public Health Officers :* Dr. A. A. Craig, Dr. R. C. Wofinden.

*Branch Council Representatives :* Professor R. J. Brocklehurst, Dr. G. L. Foss, Mr. F. J. Hector.

*Executive Committee :* Dr. D. M. Cameron, Dr. R. MacLean Courtney, Dr. W. R. Cole, Mr. A. G. Palin, Dr. H. K. V. Soltau.

*Public Relations Committee Secretary :* Dr. L. G. Robertson.

BARNSTAPLE DIVISION

THE officers for the year are : Chairman, Dr. Valentine ; Vice-Chairman, Mr. Killard-Leavey ; Hon. Secretary, Dr. S. G. Brook ; Hon. Treasurer, Mr. K. G. W. Saunders ; Representative on the Branch Council, Dr. Wilson ; Vice-Representative on the Branch Council, Dr. S. L. Wake ; Representative at Annual Representative Meeting, Mr. Killard-Leavey ; Vice-Representative at Annual Representative Meeting, Dr. S. G.

Brook ; Executive Committee, Drs. Stewart and Ritchie together with the above officers.

Clinical meetings which had been abandoned during the war have been revived and the first Paper was given by Dr. Chas. Seward of Exeter following a Dinner. During the next year a programme is being arranged including showing of films and demonstration of cases. Another Dinner is being held in the autumn.

### WEST SOMERSET DIVISION

ON 17th March, Mr. Rodney Maingot gave a most interesting lecture on **"The Management of Patients with Gastric and Duodenal Ulcers"** ; and on 10th April, Dr. Tovey also gave a very interesting discourse on the Rh factors.

### TROWBRIDGE DIVISION

THE Trowbridge Division of the B.M.A. held its annual meeting on Wednesday, 25th May.

Dr. W. H. Royal was appointed Chairman for the ensuing year, and Dr. P. A. H. Rivett, Secretary.

The meeting was combined with a clinical meeting at Roundway Hospital, Devizes, at which an inspection of the special departments and selected wards of the hospital was undertaken, with a demonstration of electro-convulsive therapy.

### SALISBURY DIVISION

THE Annual General Meeting was held on Sunday, 29th May : the following were appointed for the ensuing year. Chairman, Mr. A. Duff ; Vice-Chairman, Dr. P. D. Abbatt ; Representative, Dr. G. Newton Dunn; Secretary-Treasurer, Dr. G. W. D. Henderson ; Executive Committee, Dr. Greenstreet, Dr. Whitehead, senr.

## Local Medical Notes

ON 10th April, General Sir Ronald Adam opened the new library and reading room at Southmead Hospital. The opener appeared to believe this was the first time such an amenity had ever been provided : in addition to the reading room there is a service for delivering books in the wards. Southmead is now as well off as many older hospitals in this respect.

The Bristol Medical Reunion Dinner was held at the University Union (Victoria Rooms) on 20th April. Sir Lionel Whitby, C.V.O., M.C., M.D., F.R.C.P., was the guest of honour and 160 medical men and women were present. The arrangements were in the experienced hands of Dr. R. C. Clarke : good eating, *very* good drinking and reunion of old friends produced a pleasant and memorable occasion.

APPOINTMENTS

**Order of the Hospital of St. John of Jerusalem.**—*Officers*, A. P. Gorham, M.B.; *Serving Brothers*, J. J. Giraldi, O.B.E., M.R.C.S., Surgeon Commander J. L. S. Coulter, D.S.C., M.R.C.S.

**Medical Officer of Health for Gloucestershire.**—G. F. Bramley, M.D., D.P.H.

**United Bristol Hospitals.**—

J. H. Middlemiss, M.D., D.M.R.D., F.F.R., Director of the Radiodiagnostic Department.

Robert P. Warin, M.D., M.R.C.P., Dermatologist.

UNIVERSITY OF BRISTOL

MEDICAL PRIZES AND SCHOLARSHIPS, 1948–49

*Thomas Francis Edgeworth and Francis Henry Edgeworth Prize.*—N. G. Sanerkin.

*Edward Fawcett Memorial Prize.*—F. J. Applebe and N. G. Sanerkin, jointly.

*Foyle Prize.*—N. G. Sanerkin.

*Mackie Prize.*—Mr. G. Walters.

*Russell Cooper Prize.*—Mr. E. A. Houghton.

*Lady Haberfield Scholarship.*—Miss D. Ellis.

*Marshall and Clarke Prize.*—Mr. E. A. Houghton.

*Sanders Scholarship.*—Mr. J. D. Sheward.

*Henry Clarke Prize.*—Mr. P. C. Farrant.

*Medical Suple Prize.*—Mr. J. D. Sheward.

*Surgical Suple Prize.*—Mr. D. M. Gambier.

*Tibbits Memorial Prize.*—Mr. H. Schnieden.

*Barrett Roué Prize.*—Mr. H. Schnieden.

*Augustin Prichard Prize.*—Mr. B. B. Beeson.

DEGREES AND DIPLOMAS

**University of Bristol.**—

M.B., CH.B. (*with Second Class Honours*): D. M. Gambier (with Distinction in Public Health), June M. Smith (with Distinction in Obstetrics). *Pass*: Joan H. Barnes (with Distinction in Public Health), B. B. Beeson, D. J. Brain, Joan K. Cheeseman, Jennifer M. Comely, P. C. Farrant, Elizabeth M. Fraser, Patricia M. Gilbert, Pamela M. Hellings, Sybil E. Jacob, C. D. Linton, J. P. Martin, Elizabeth M. Morgan, June Morgan, P. A. Normandale, J. S. R. R. Old, H. Schneiden, J. D. Sheward (with Distinction in Medicine), Medora Storkey, M. P. Walker, G. Walters, Olwen J. West, Catherine C. White.

M.B., CH.B.—*Second Examination*: N. G. Blackwell, R. W. Digby, S. T. Guest, M. E. Jackman, Marguerite A. R. King, R. D. Lalloo, Sheila A. Martyn, S. E. Mbanefo, J. H. Perry, W. E. Smith, D. W. G. Stone, J. T. Wheeler.

D.P.H.—K. G. Bergin, Peggy Beynon, D. W. Browne, J. E. Krzywiec, J. D. Medhurst.